INTIAL and RENEWAL APPLICATION
for
CLINICAL LABORATORY PERSONNEL TRAINING PROGRAM

Department of Health
Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257
(850) 245-4355
http://www.floridasclinicallabs.gov/

Please read the following instructions before completing the application:

1. Attach a certified check or money order to the application payable to the Department of Health. **Do not send cash.**

2. All training programs (universities, community colleges, vocational technical schools, hospitals or laboratory based) for laboratory personnel should complete this application.

3. All programs must submit additional supporting documents except for nationally accredited programs.

4. The History Questions shall be completed by the Program Director or Training Coordinator.

COMPLETING THE APPLICATION:

INITIAL Application and Licensure Fees:

Initial Application Fee - $200.00 (non-refundable)
Initial Licensure Fee - $200.00
Unlicensed Activity Fee - $5.00
Total: $405.00

RENEWAL Application and Licensure Fees:

Renewal Licensure Fee - $300.00
Unlicensed Activity Fee - $5.00
Total: $305.00

Please submit the fees by money order or cashiers check, application and supporting documentation to the following address:

Board of Clinical Laboratory Personnel
Post Office Box 6330
Tallahassee, FL 32314-6330

If you have any additional documents to submit after your application has been mailed, please send to:
(supporting documents/correspondence with NO fees)

Department of Health
Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257

***As a reminder to all applicants, please note that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.**

INITIAL and RENEWAL APPLICATION INSTRUCTIONS/CHECKLIST
for
CLINICAL LABORATORY PERSONNEL TRAINING PROGRAM

(NAACLS, CAAHEP, or ABHES - ONLY)

(Please refer to **Rule 64B3-9, F.A.C.**) - Fees
(Please refer to **Rule 64B3-3, F.A.C.**) - Approval of Clinical Laboratory Personnel Training Programs

1. _____**Submit appropriate application and licensure fees**
   Initial Fees - $405.00
   Renewal Fees - $305.00

2. _____**Personnel/Instructors Roster (include FL license number)**
   Attach roster –
   - list all laboratory personnel including the level of licensure and license number;
     and
   - Instructors shall teach only in areas licensed as a technologist, supervisor and director; or 3 years of experience in clinical laboratory science education.

3. _____ **Student Enrollment Roster**
   Attach roster –
   - All trainee names shall be reported to the board upon acceptance into the clinical laboratory personnel training program. Please include program start date and anticipated graduation date.

4. _____**Accreditation Verification**
   (NAACLS, CAAHEP, ABHES)

5. _____**Training – length of program**
   (List the number of hours students spend in class and in the laboratory. Specify the approximate weeks per year or percent of time per year spent in practical training and in lecture/didactic work. Attach the last CAP, JC, or state survey of the laboratory, if this is a laboratory-based program regardless of national accreditation.)

6. _____**Program Director (include resume)**
   Program shall have a director who holds national certification listed in subsections 64B3-5.007(2) and (4), F.A.C., **and;**
   - holds a doctoral or master's degree in a chemical, biological or clinical laboratory science and 3 years of experience in clinical laboratory science education;
     or
   - BS in a chemical, biological or clinical laboratory science and 5 years of experience in clinical laboratory science education.

7. _____**Training Program Affiliates**
   - Name of laboratory
   - Address
   - Type of laboratory
   - Telephone number
   - Hospital or laboratory contact person
   - AHCA license number

INITIAL and RENEWAL APPLICATION INSTRUCTIONS/CHECKLIST
for
CLINICAL LABORATORY PERSONNEL TRAINING PROGRAM

(COLLEGE, UNIVERSITY, VO-TECH or HOSPITAL/LAB)

(Please refer to **Rule 64B3-9, F.A.C.**) -Fees
(Please refer to **Rule 64B3-3, F.A.C.**) - Approval of Clinical Laboratory Personnel Training Programs

1. _____**Submit appropriate application and licensure fees**
   Initial Fees - $405.00
   Renewal Fees - $305.00

2. _____**Personnel/Instructors Roster - include FL license number**
   Attach roster –
   - list all laboratory personnel including the level of licensure and license number;
     and
   - Instructors shall teach only in areas licensed as a technologist, supervisor and director; or 3 years of experience in clinical laboratory science education.

3. _____ **Student Enrollment Roster**
   Attach roster –
   - All trainee names shall be reported to the board upon acceptance into the clinical laboratory personnel training program. Please include program start date and anticipated graduation date.

4. _____ **Self Study**
   Submit self study document at the time of the initial application and shall update within 6 months of any major changes in curriculum, sponsorship, instructors, student enrollment, or clinical affiliates.

5. _____ **Training – length of program** (List the number of hours students spend in class and in the laboratory. Specify the approximate weeks per year or percent of time per year spent in practical training and in lecture/didactic work. Attach the last CAP, JC, or state survey of the laboratory, if this is a laboratory-based program regardless of national accreditation.)

6. _____ **Program Director (include resume)** Program shall have a director who holds national certification listed in subsections 64B3-5.007(2) and (4), F.A.C., **and;**
   - holds a doctoral or master's degree in a chemical, biological or clinical laboratory science and 3 years of experience in clinical laboratory science education;
     or
   - BS in a chemical, biological or clinical laboratory science and 5 years of experience in clinical laboratory science education.

7. _____**Training Program Affiliates**
   - Name of laboratory
   - Address
   - Type of laboratory
   - Telephone number
   - Hospital or laboratory contact person
   - AHCA license number

INITIAL and RENEWAL APPLICATION
for
CLINICAL LABORATORY PERSONNEL TRAINING PROGRAM

(Client 6603); (xact 1010)

Mail To: Board of Clinical Laboratory Personnel
Post Office Box 6330
Tallahassee, Fl 32314-6330
(850) 245-4355
http://www.floridasclinicallabs.gov/

APPLICATION CATEGORY:

(xact 1010)	Application Fee (Non-refundable)	$200.00	(xact 2020)	Renewal – License Fee	$300.00
	Initial License Fee	$200.00		Unlicensed Activity Fee	$ 5.00
	Unlicensed Activity Fee	$ 5.00			
	TOTAL:	**$405.00**		**TOTAL:**	**$305.00**

Please review **Rule 64B3-3, F.A.C.**

PROFILE DATA: (Please print or type)

1. **PROGRAM NAME:** _____

MAILING ADDRESS: _____
(Street and Number) (Suite Number)

_____
(City) (State) (Zip)

TELEPHONE: _____ **FAX:** _____

E-MAIL ADDRESS: _____

(**Email Notification**: If you want to notified of the status of your application by email please check the **"YES"** box and write your email address on the line provided above. If you choose this form of notification you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the board office info@floridasclinicallabs.gov . Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing. [ ] YES [ ] NO

ACCREDITATION PROGRAM: (Please select from one of the following categories)

- **CLP training program:**
  [ ] NAACLS [ ] CAAHEP [ ] ABHES
  or
- **Regional accrediting agency:**
  [ ] College [ ] University [ ] Vo-Tech
  or
- **Approved Laboratory - licensed under Section 483.091, F.S. or federal or out of state laboratories which have standards equivalent to those prescribed in Chapter 483, Part I, F.S., and rules:**
  [ ] Hospital/Lab

PROGRAM TYPE:

[ ] Medical Technologist (MT) [ ] Medical Laboratory Technician -MLT-AD
[ ] Medical Laboratory Technician – Certificate (MLT-C) [ ] Immunohematology/Blood Banking
[ ] Histology [ ] Cytology [ ] Cytogenetics
[ ] Andrology [ ] Embryology [ ] Histocompatibility

2. EDUCATION AND TRAINING DATA:

- **Education:** (Minimum education requirements for entrance):

(School Name Granting Degree) (Degree Awarded)

- **Training:** Please select the category (which includes the length of program).

SELECT ONE OPTION ONLY		CATEGORY	LENGTH of PROGRAM	COURSE TRAINING
(1)a.		Clinical Chemistry, Hematology, Immunohematology, Microbiology, and Serology/Immunology – **(Combination Categories);** **and/or**	minimum (1) year; **or**	integrated instruction covering all categories
b		Indicate category (single category listed above): _____	minimum (3) months	instruction (single category)
(2)a		Andrology; **and/or**	minimum (6) months	instruction
d		Embryology		
(3)		Histology	minimum (1) year	instruction
(4)		Cytogenetics, Radioassay, Blood Gas Analysis and Cytology – **(TECHNOLOGIST level ONLY)**	minimum (1) year	instruction
(5)		Molecular Pathology	minimum (6) months	instruction

a. Do you offer HIV/AIDS and Medical Errors education? [ ] YES [ ] NO

b. Name of Training Coordinator responsible for oversight of training program (attach resume):

(Last) (First) (Highest Degree Held) (Certification)

c. Name of Program Director, if different than Coordinator (attach resume):

(Last) (First) (Highest Degree Held) (State License #)

3. CLP TRAINING PROGRAMS – Please review **Rule 64B3-3, F.A.C.** and submit the following:

- **Personnel/Instructors Roster** (Attach personnel/faculty roster, include license number and level of licensure)
- **Student Roster** (program start and anticipated graduation date)

4. HISTORY QUESTIONS:

Pursuant to Section 456.0635, Florida Statutes, the following questions are being asked. If you answer yes to any of the following questions, explain on a separate sheet of paper providing accurate details and submit copies of supporting documentation.

1. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409 (relating to social and economic assistance), Chapter 817 (relating to fraudulent practices), Chapter 893, Florida Statutes (relating to drug abuse prevention and control) or a similar felony offense(s) in another state of jurisdiction? Yes _____ No _____ **(If you responded "No", skip to #2)**

   a. If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation? Yes _____ No _____

   b. If "yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes). Yes _____ No _____

   c. If "yes" to 2, for felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? Yes _____ No _____

   d. If "yes" to 1, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? Yes _____ No _____ **(If "yes", please provide supporting documentation)**

2. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes _____ No _____

   a. If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? Yes _____ No _____

3. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? Yes _____ No _____ **(If "No", do not answer 3a.)**

   a. If the applicant any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated but reinstated, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been in good standing with the Florida Medicaid Program for the most recent five years? Yes _____ No _____

4. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes _____ No _____ **(If "No", do not answer 4a or 4b.)**

   a. If the applicant any principal, officer, agent, managing employee, or affiliated person of the applicant been in good standing with a state Medicaid program for the most recent five years? Yes _____ No _____

   b. Did the termination occur at least 20 years before to the date of this application? Yes _____ No _____

5. If the applicant any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? Yes _____ No _____

CLINICAL AFFILIATE LIST

AFFILIATE 1:
Name of Laboratory: _____ Type of Lab: _____

Address: _____ Telephone Number: _____
(Street and Number)

_____ Hospital or Lab Contact: _____
(City) (State) (Zip)

AHCA License Number: _____

AFFILIATE 2:
Name of Laboratory: _____ Type of Lab: _____

Address: _____ Telephone Number: _____
(Street and Number)

_____ Hospital or Lab Contact: _____
(City) (State) (Zip)

AHCA License Number: _____

AFFILIATE 3:
Name of Laboratory: _____ Type of Lab: _____

Address: _____ Telephone Number: _____
(Street and Number)

_____ Hospital or Lab Contact: _____
(City) (State) (Zip)

AHCA License Number: _____

AFFILIATE 4:
Name of Laboratory: _____ Type of Lab: _____

Address: _____ Telephone Number: _____
(Street and Number)

_____ Hospital or Lab Contact: _____
(City) (State) (Zip)

AHCA License Number: _____

AFFILIATE 5:
Name of Laboratory: _____ Type of Lab: _____

Address: _____ Telephone Number: _____
(Street and Number)

_____ Hospital or Lab Contact: _____
(City) (State) (Zip)

AHCA License Number: _____